2011 Military Health System Conference

Incentivizing Quadruple Aim Performance: Initial Results of the MHS Performance Planning Pilots

The Quadruple Aim: Working Together, Achieving Success

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Navy Medicine

Outline

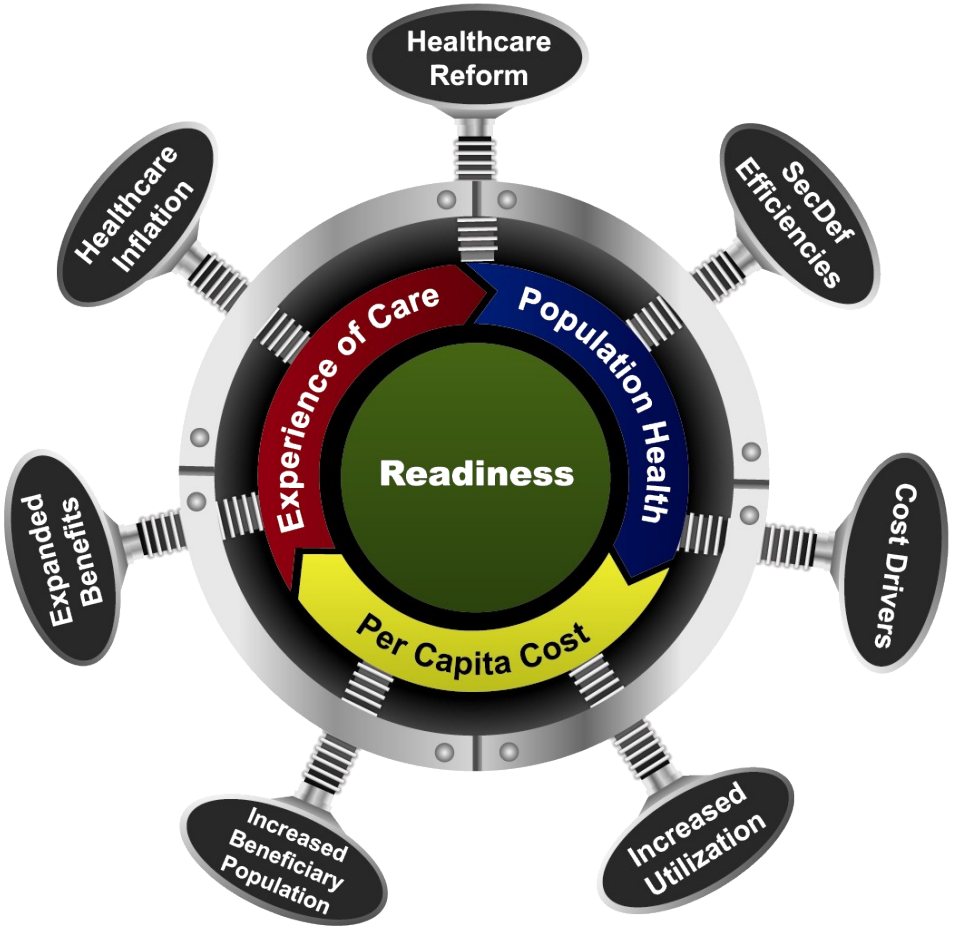
- Provide Overview of the MHS Performance Pilots
- Review the hybrid model of reimbursement
- Describe the design of these plans including strategic initiatives
- Review the context of these plans in the context of Pensacola's plan
- Highlight some preliminary data

Desperately Seeking the Quadruple Aim

"Widgets"

"Health"

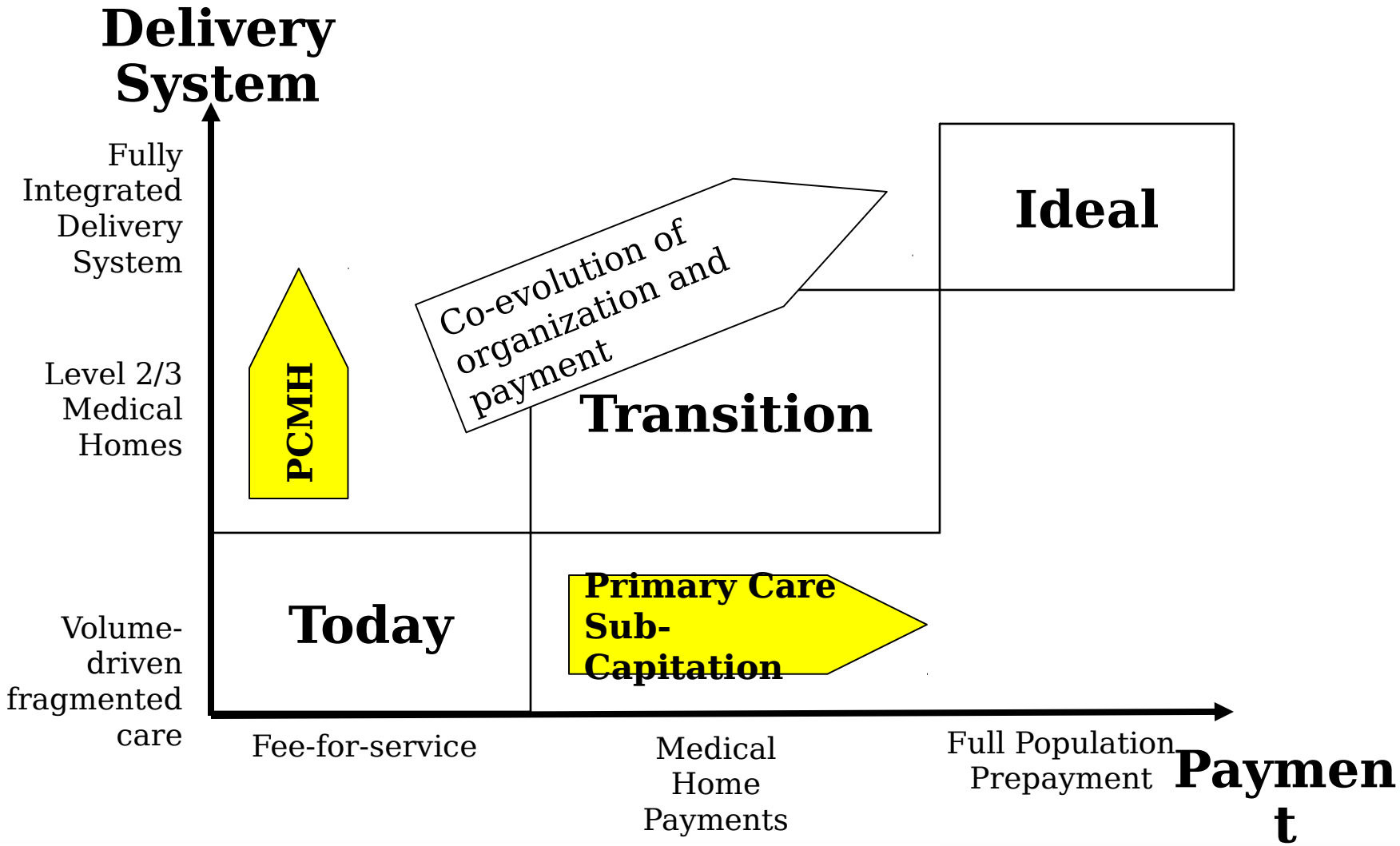
The Quadruple Aim Pressures



Why Performance Pilots?

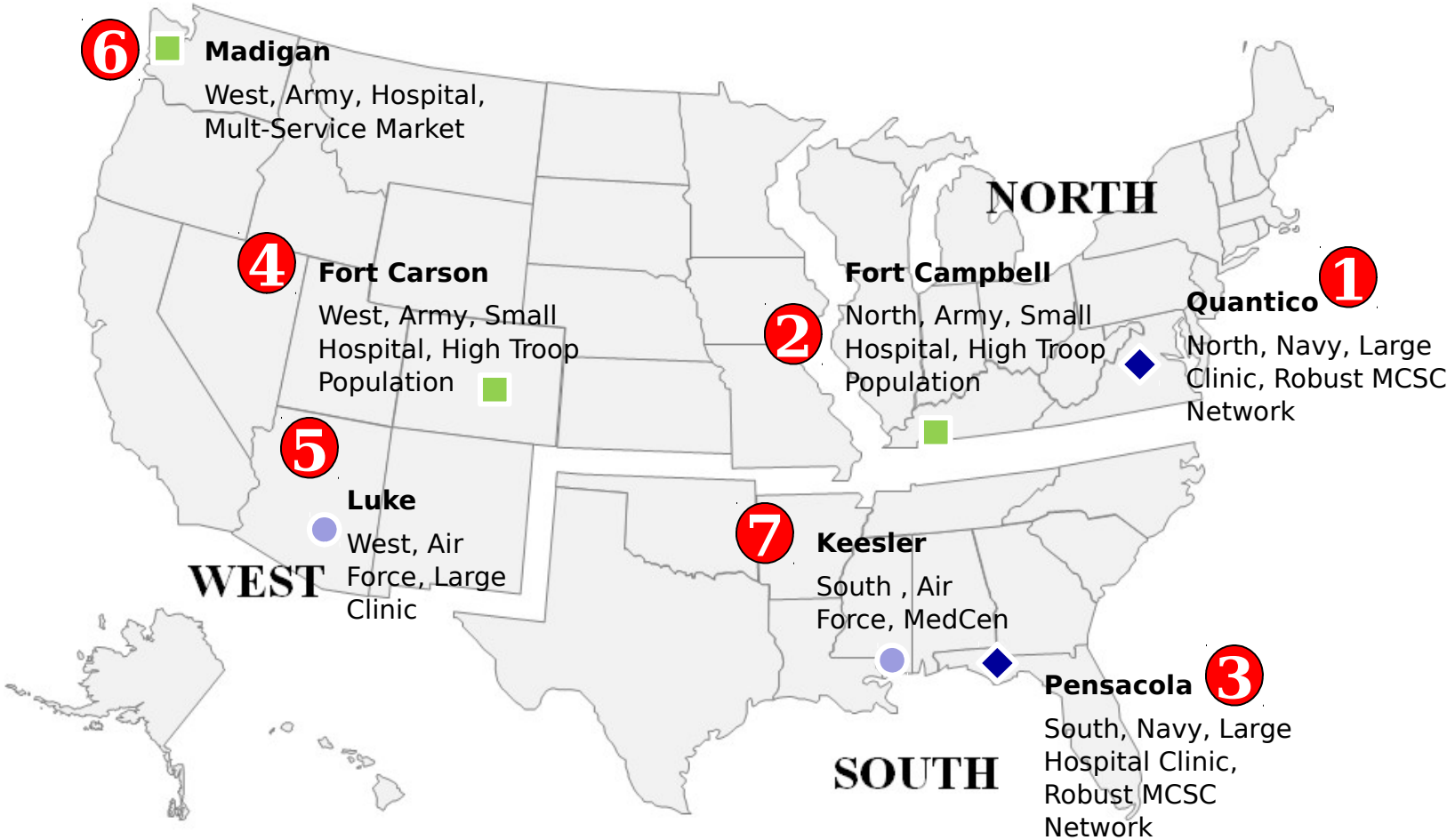
- PPS incentivizes the wrong behaviors:
  - Production of healthcare, not health
  - No incentive to demand manage utilization
  - Fails to reward meaningful outcomes:
    - Patient satisfaction
    - Patient access
    - Decreased utilization of network care, including ER, where possible
    - Improved efficiency in delivery of care (PMPM)

Transition In Both Payment and Delivery Systems



Adapted From "From Volume To Value: Better Ways To Pay For Health Care", Health Affairs, Sep/Oct 2009.

Pilot Sites


6
Madigan
West, Army, Hospital, Mult-Service Market
NORTH
4
Fort Carson
West, Army, Small Hospital, High Troop Population
2
Fort Campbell
North, Army, Small Hospital, High Troop Population
1
Quantico
North, Navy, Large Clinic, Robust MCSC Network
5
Luke
West, Air Force, Large Clinic
WEST
7
Keesler
South , Air Force, MedCen
3
Pensacola
South, Navy, Large Hospital Clinic, Robust MCSC Network
SOUTH
Army
Navy
Air Force

The Pilot

- Intended to replace PPS if successful
- Components:
  - PCMH Primary Care: Capitation
  - Non PCMH Primary Care: Fee for service
  - Care Management Fee
  - Specialty Care: Fee for service
  - Inpatient: Fee for service
  - APV: Fee for service
  - P4P

Pay for Performance (P4P)

- Mammography
- Colorectal screening
- Cervical cancer screening
- A1C screening
- LDL < 100
- A1C > 9.0
- Oryx measures

Pay for Performance (P4P)

- Satisfaction
- PCM continuity
- 3rd next avail (Routine)
- 3rd next avail (Acute)
- ER utilization /100 enrollees
- PMPM inflation

Strategic Initiatives

Strategic Initiative #1
Med Home Port Roll Out

- Access to Care
  - PCM continuity
  - 3rd next available
  - Satisfaction
- Enrollment
- Telephony
  - Time to answer
  - Abandonment rate
- Readiness
  - IMR
  - FMR
  - Reclama deployment
- ER visits
- Specialty referral
- Primary Care Recapture

Strategic Initiative #2
Specialty Optimization

- Referrals to network
- Referrals accepted MTF
- Receipt of CLR
- Admin closure of consults
- Primary Care Survey:
  - Satisfaction with availability of specialists
- Unneccessary consultation of specialists
- ROFRs captured
- Average daily census

Strategic Initiative #3
Capture Meaningful Data

- Inpatient coding accuracy
- Outpatient coding accuracy
- CHCS bookable hours vs DMHRSi
- DMHRSi timecards (rejected, errors)
- DMHRSi accuracy
- Records completed (inpt and outpt)
- Incomplete encounters
- Write back errors

Strategic Initiative #4
Taking Care of People

- Staff satisfaction working at NHP
- DH/DIR satisfaction with hiring/firing process
- DIR feeling wrong body in wrong “seat”
- Patient satisfaction with courtesy
- Number of vacant positions; beyond 100 days
- Average time to hire GS
- Average time to hire CON

PCMH: At The Core of Strategy

Anticipated Effects of PMCH in MHS

- Improved
  - Access to Care
  - Team continuity
  - PCM continuity
  - Patient satisfaction

- Reduced Costs of Care
  - Unnecessary:
    - ER use
    - Network care
    - Ancillary tests
    - Hospitalizations
    - Specialty visits

Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence From Prospective Evaluation Studies in the United States

Updated November 16, 2010

Kevin Grumbach, MD, Paul Grundy, MD, MPH

- Group Health, Geisenger, VA, Blue Cross Blue Shield, Medicaid (NC, CO) and others…
  - Decreased PMPM
  - Decreased ER utilization
  - Decreased admissions
  - Improved quality metrics
  - Improved customer satisfaction (patients/staff)

Pilot Basics

- Enter after achieving level 2 NCQA recognition
- Capitation/Care Management Fee primary care
- Rewards for population health management:
  - $2.50; $5.00; $10.00 per relevantly screened enrollee depending on performance
- Oryx rewarded if 100% compliance:
  - $400 per relevant patient
- Satisfaction:

Pilot Basics

- Annual Awards:
  - PCM Continuity $20 (60%) or $10 (40%) per enrollee * % met
  - 3rd available $1.50 (60%); $.50 (40%); $.25 (<40%) per enrollee * % met
- Fee for service:
  - Specialty $36.61 per RVU
  - APV $67.31 per APC
  - Inpatient $ 3,107 per RWP
  - Mental Health Bed Day $769

ER Utilization

- DECREASE IN RATE:
  - <55/100: 20% of savings as a bonus
  - <65/100: 10% of savings as a bonus
  - >65/100: 5% of savings as a bonus
- INCREASE IN RATE:
  - <40/100: 0% of costs as a penalty
  - <55/100: 5% of costs as a penalty
  - <65/100: 10% of costs as a penalty
  - >65/100: 20% of costs as a penalty

PMPM Management: Goal 6%

- Increase in PMPM is less than 4 percentage points below the MTF specific target: 20% of the $ difference as a bonus
- Increase in PMPM is less than 2 percentage points but higher than 4 percentage points below the MTF specific target: 10% of the $ difference as a bonus
- Increase in PMPM is below the MTF specific target 0%: (no penalty or bonus)
- Increase in PMPM is less than 2 percentage points above the MTF specific target: 10% of the $ difference as a penalty
- Increase in PMPM is greater than 2 percentage points above the MTF specific target: 20% of the $ difference as a penalty

At A Glance.....

Mammography	% of women enrolled to a MTF, age 52 - 69, who had a mammogram in the previous 24 months.	80.0%	**2.0%**	Monthly award: > 80.4% = $10.00 per relevantly screened enrollee 71.1% - 80.4% = $5.00 per relevantly screened enrollee < 71.1% = $2.50 per relevantly screened enrollee (based on the HEDIS 90th and 50th percentiles)	2,422	1,939	48	1,987	$ 122,122.00	
Colorectal	% of adults enrolled to an MTF, age 51 - 80, who have had appropriate colorectal cancer screening.	71.6%	**3.4%**	Monthly award : > 68.4% = $10.00 per relevantly screened enrollee 55.8% - 68.4% = $5.00 per relevantly screened enrollee < 55.8% = $2.50 per relevantly screened enrollee (based on the HEDIS 90th and 50th percentiles)	6,856	4,911	284	5,194	$ 27,971.12	$ 559,811.32
Cervical	% of women continuously enrolled to a MTF age 24 - 64 years who had cervical cancer screening in the past three years.	83.0%	**6.0%**	Monthly award : > 87.8% = $10.00 per relevantly screened enrollee 82% - 87.8% = $5.00 per relevantly screened enrollee < 82% = $2.50 per relevantly screened enrollee (based on the HEDIS	7,189	5,966	431	6,397	$ 409,718.20	

Pensacola PMCH Pilot

- 33,795 enrollees in medical homes
- Historical RVU production valued at $9,105,298 in non capitated environment

But what if we de-incentivized burn and churn and incentivized production of health?

Performance Pilot

- Capitated Funding:
  - $267.39 per enrollee
  - 33,795 enrollees

  $ 8,088,030.00

- Care Management Fee **(level 2 NCQA)**
  - $5.00 per enrollee
  - 33,795 enrollees

  $ 2,027,700.00

- Pay For Performance
  - Mammography
  - Cancer screenings
  - Diabetes HEDIS
  - Oryx measures
  - PCM continuity
  - 3rd next available
  - Satisfaction ratings
  - PMPM Inflation
  - ER utilization

Pay For Performance

		Capitation	$ 8,088,030.00
		Care Mgmt Fee	$ 2,027,700.00
		Subtotal	**$10,115,730.00**
Metric	**Baseline***	**Goal**	**Reward**
Mammography	80%	↑ 82%	$122,122.00
Colorectal	71.6%	↑ 75%	$27,971.12
Cervical	83%	↑ 89%	$409,718.20
A1C screen	89%	↑ 95%	$92,937.40
LDL < 100	44.4%	↑ 54.4%	$69,395.00
A1C > 9.0	21%	↑ 18%	$78,206.20
		↓ Additional P4P	**$800,349.92**

Pay For Performance Cont.

Metric	Baseline	Goal	Reward
PCM Continuity	38.8%	60%	$328,652.16
3rd next routine	79.2%	86.4%	$94,842.94
3rd next acute	55.6%	64.8%	$383.984.70
Satisfaction – care	92.3%	92.3%	--
		Additional P4P	**$807,479.80**

*NOTE: rewards are based on increases or decreases from baseline

Pilot Basics

Capitation	$ 8,088,030.00
Care Mgmt Fee	$ 2,027,700.00
P4P HEDIS	$800,349.92
P4P Experience	$807,479.80
Subtotal	**11,723,559.72**

- Doesn't include
  - Oryx measures
  - ER Utilization
    - Earn or lose based on increase/decrease
  - PMPM Costs
    - Earn or lose based on increase/decrease of inflationary costs

Risks

PPS Environment: $9,105,298.00

Capitation	$ 8,088,030.00
Care Mgmt Fee	$ 2,027,700.00
P4P HEDIS	$800,349.92
P4P Experience	$807,479.80
Subtotal	**11,723,559.72**

What if ER use increases?

? NCQA recognition

What if don't improve?

What if PMPM rises?

Impact on MHS Bottom Line

Demand Management of Enrollees

Reduced Utilization of Visits

Unused Capacity

Increase Enrollment

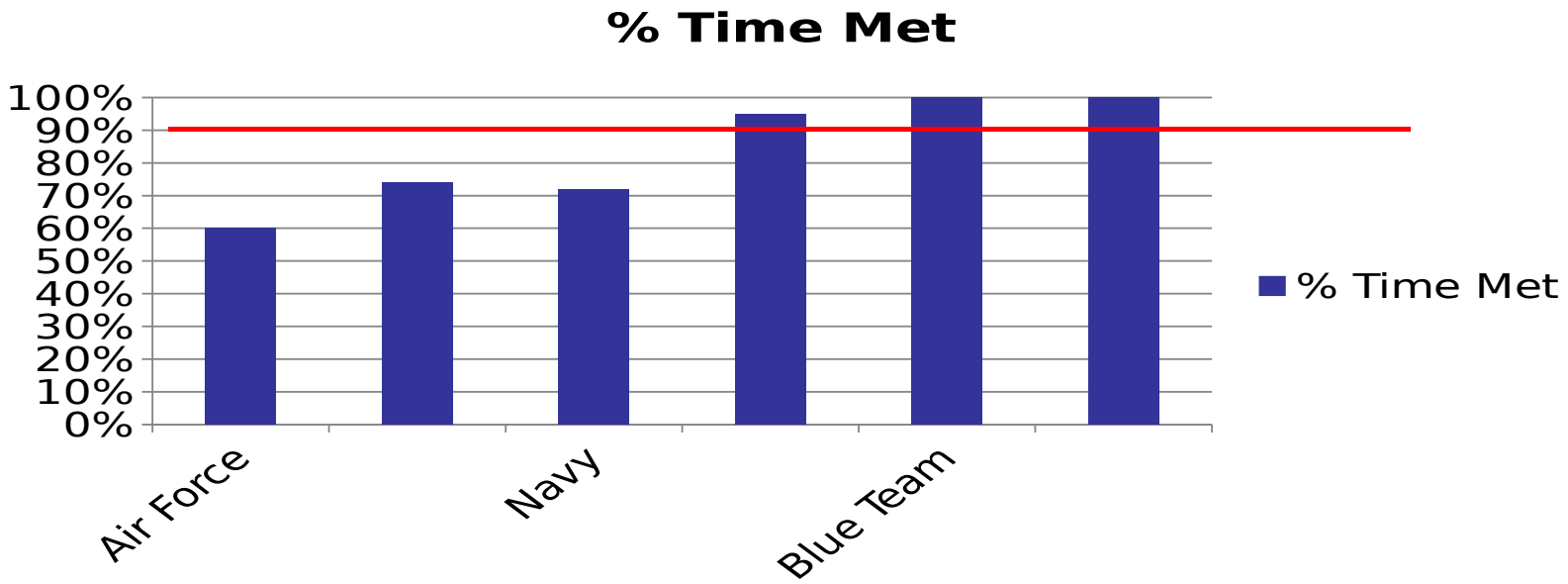
↓ Utilization + ↓ Unit Cost

PMPM $$ ↓

Why is enrollment relevant?

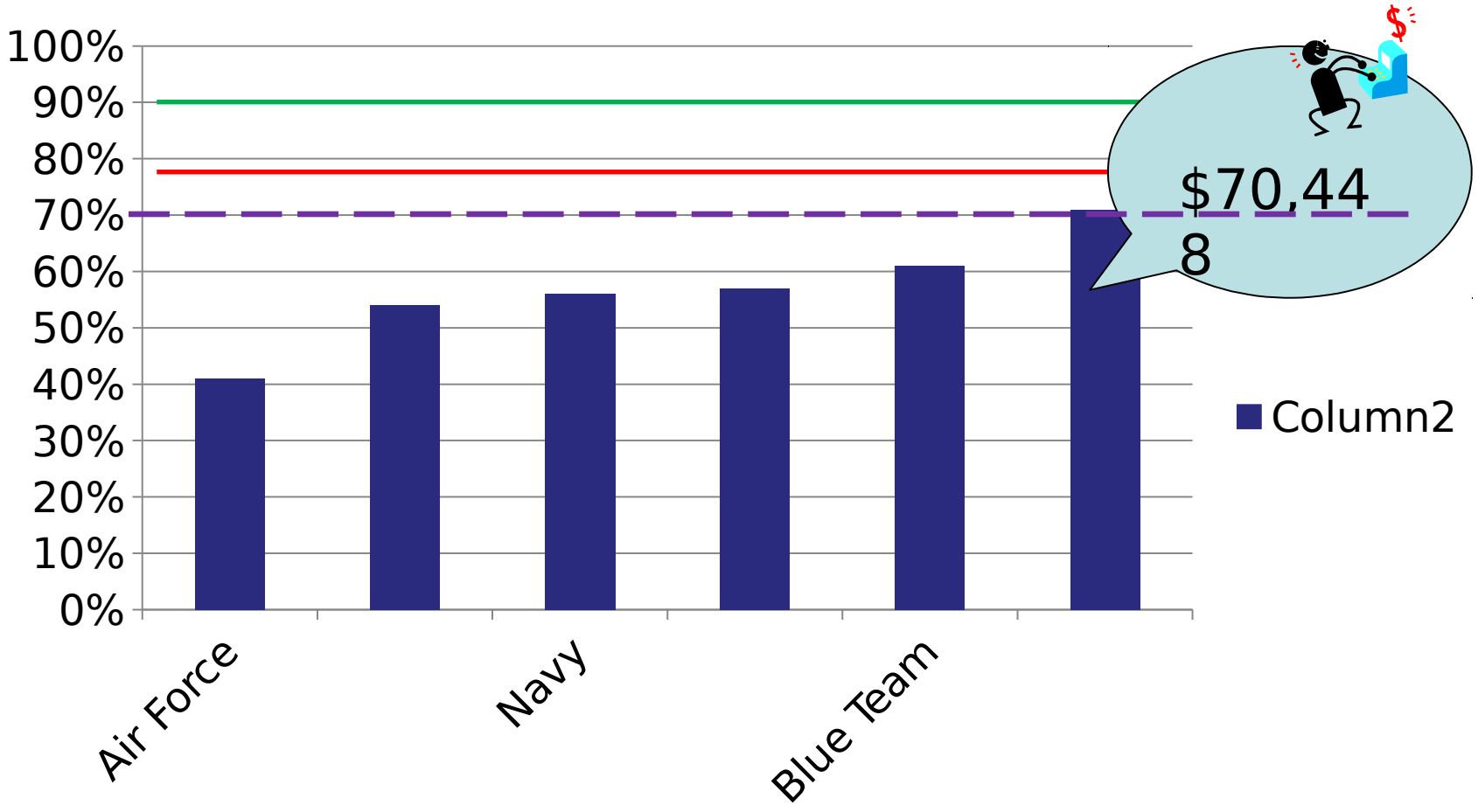
- PMPM for network enrollees: ≈ $3,500
- So for every 100 enrollees you could potentially bring back into direct care:
  - Impact 350K costs
  - Especially if your costs are mostly fixed
- Enrollment allows leveling of the playing field
  - Meaningful comparisons
  - Risk adjustment

Third Next Available – Routine Care



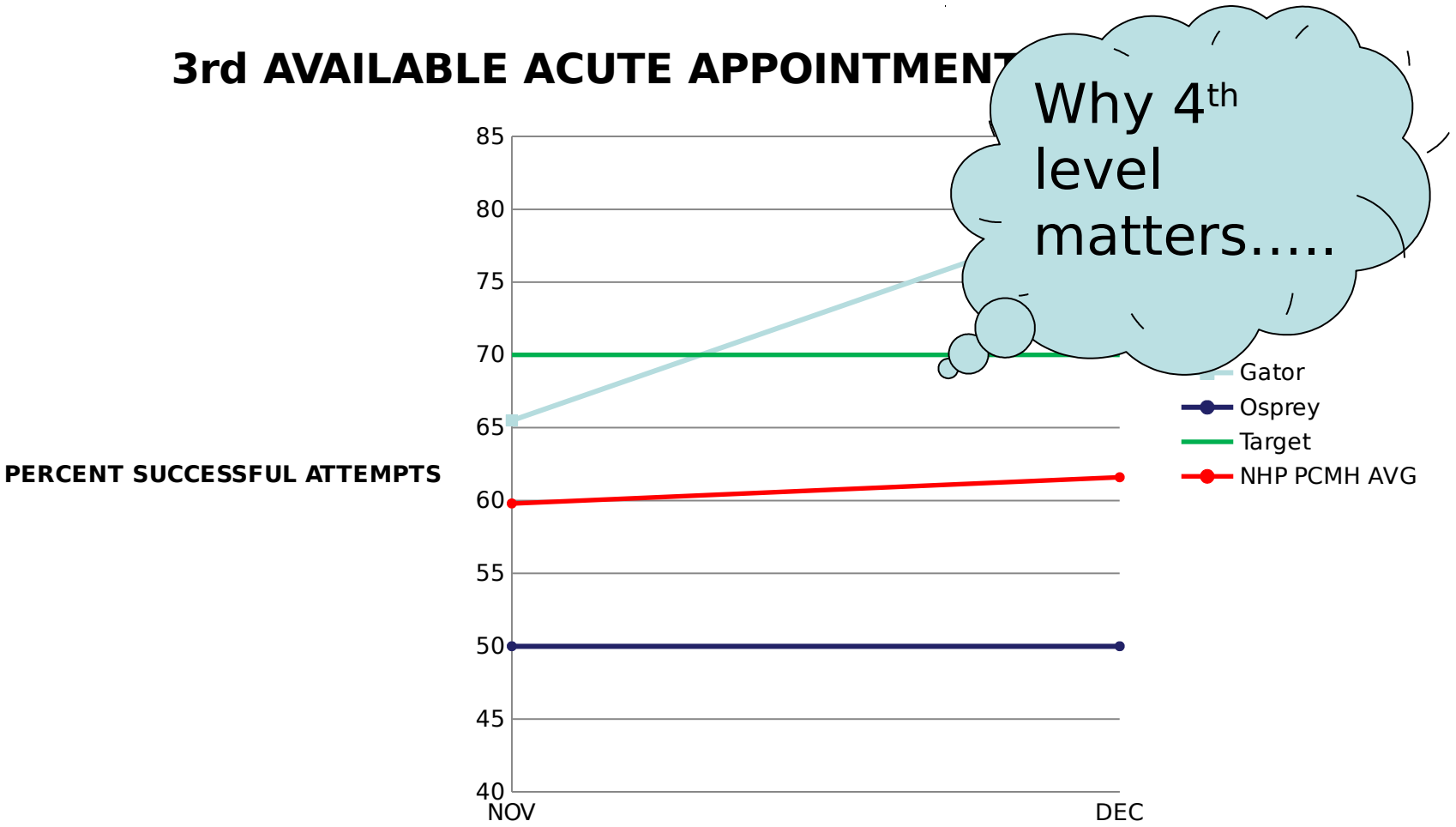
Data from MHS Insight 12/30/2010

Third Next Available – Acute Care

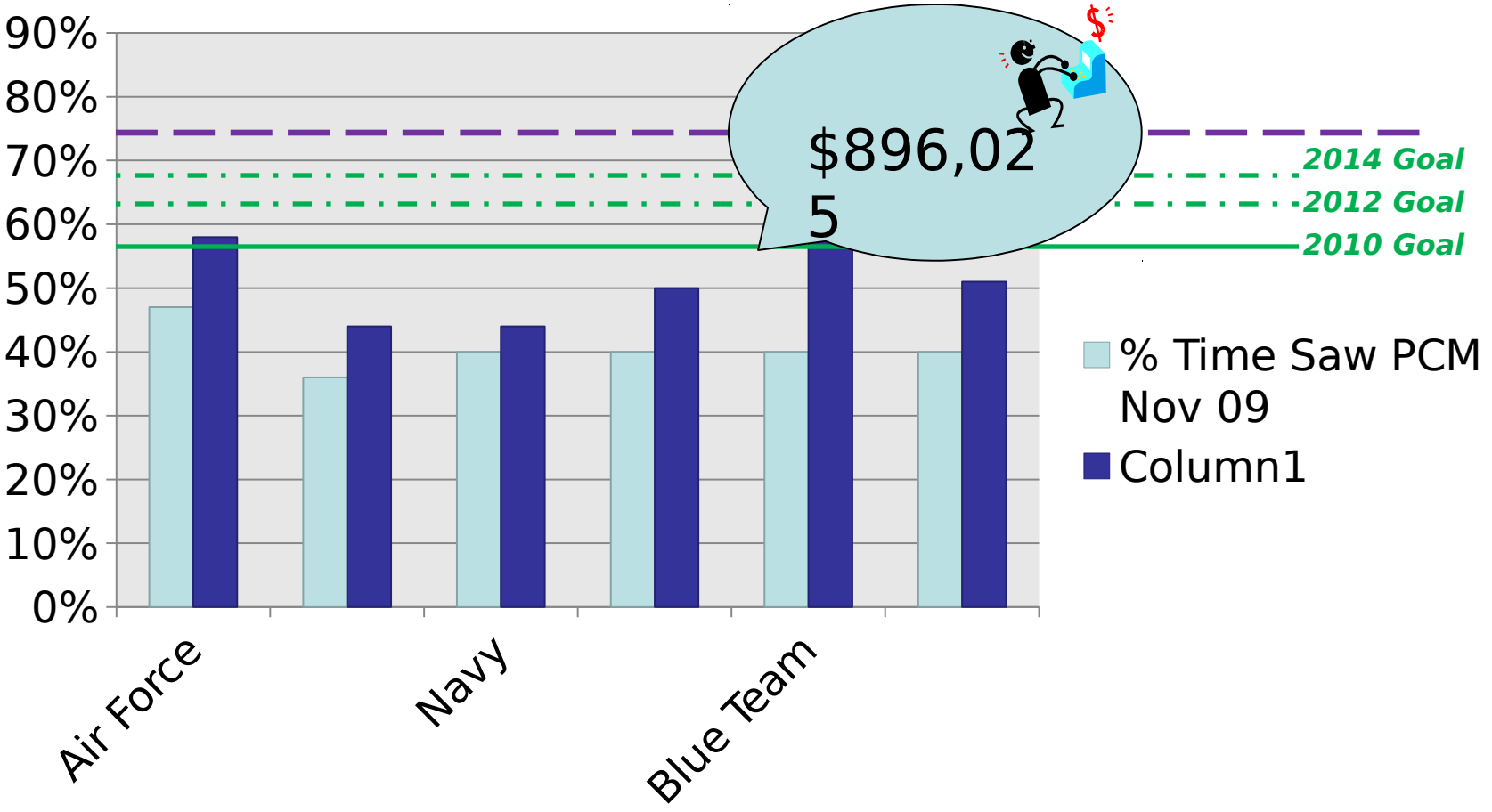


Data from MHS Insight 12/30/2010

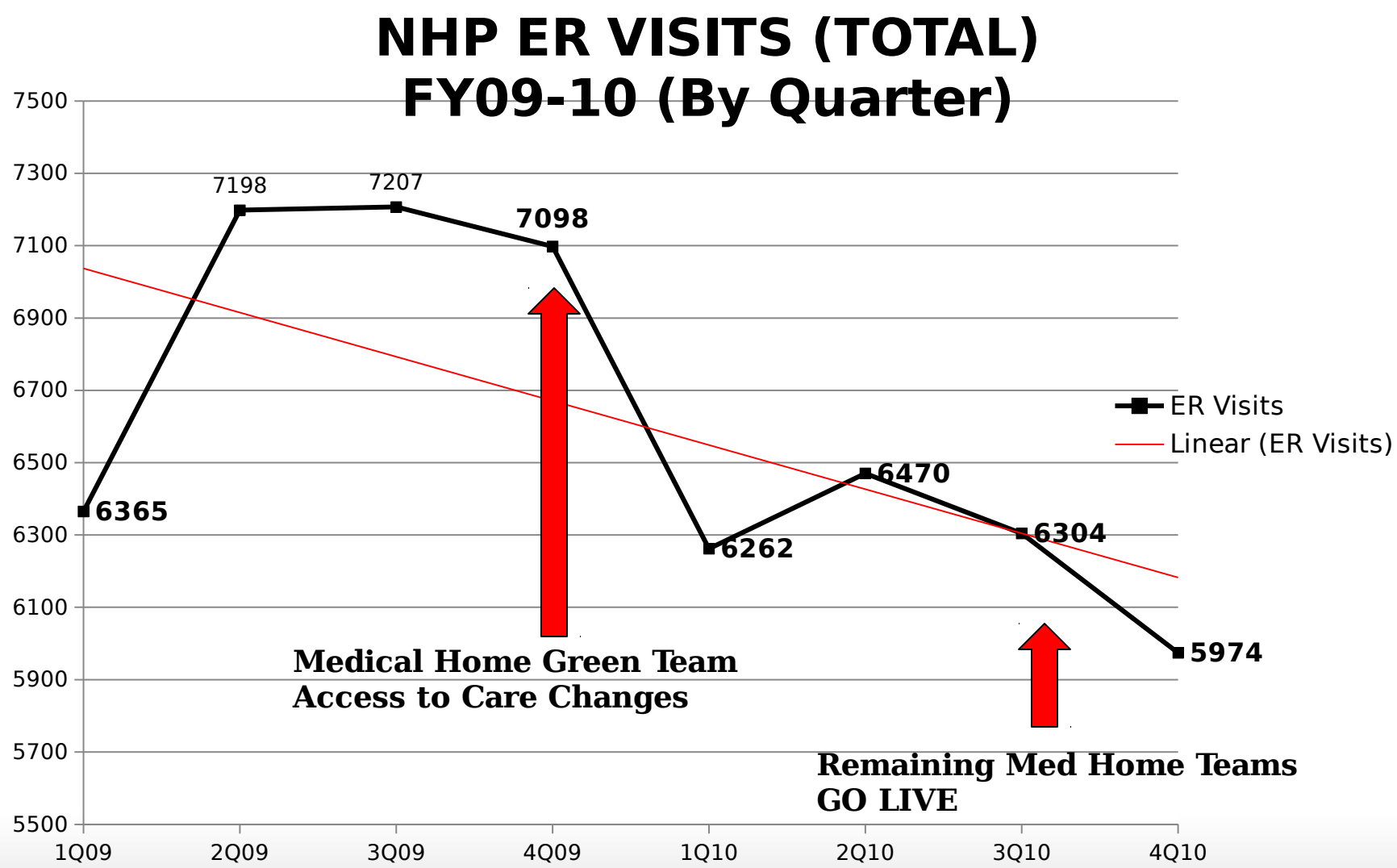
3rd Next Internal Medicine



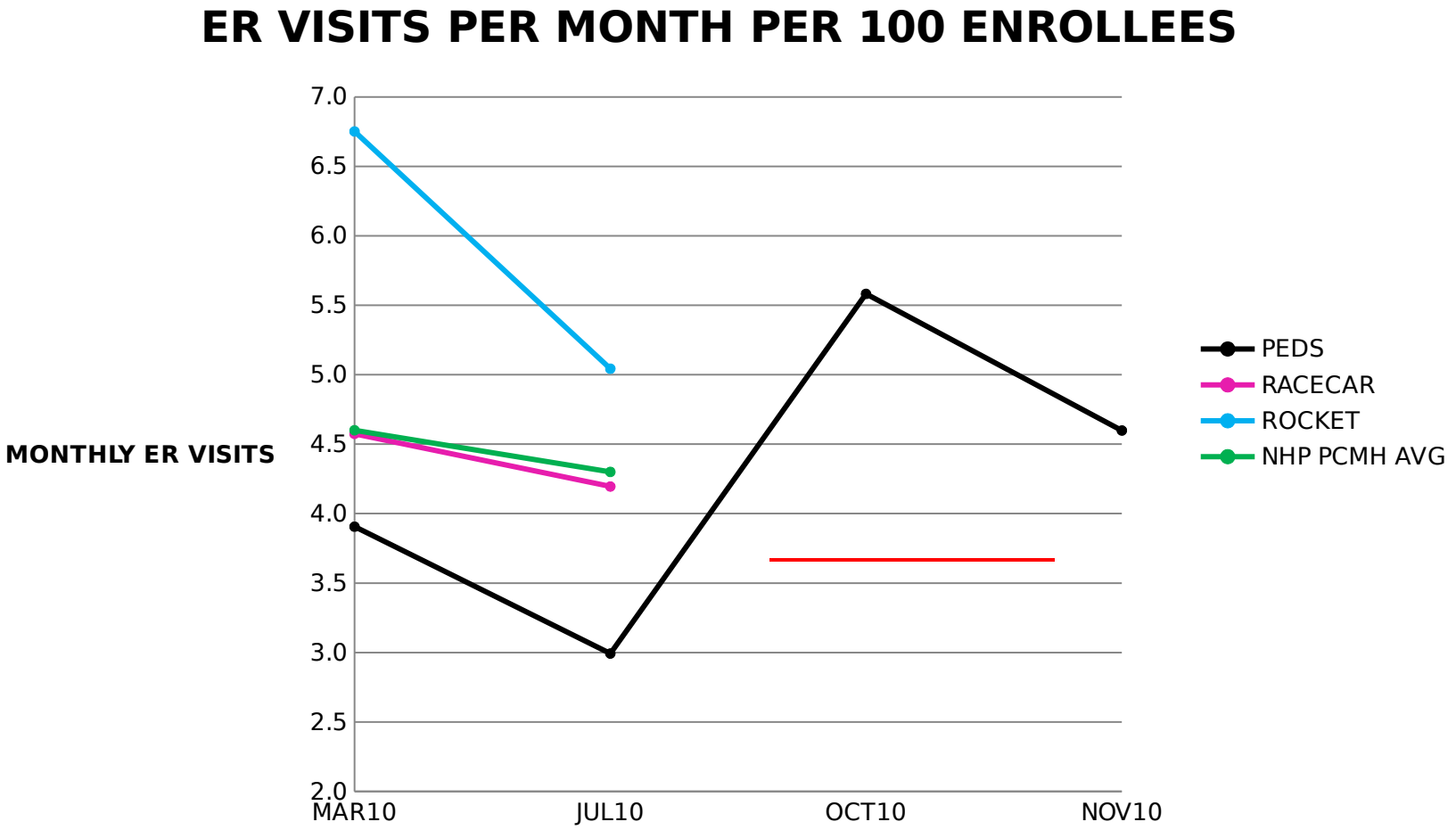
Updated PCM Continuity Metric



Total ER Visits NHP Enrollees



Pediatrics ER visits



Bottom line: Initial data monitoring, though pilot has not officially begun, suggests that focusing on key outcome metrics is driving change in behaviors in meaningful ways!

Voice of the Customer

Video

Questions?